Attachment and psychopathy in forensic patients

van den Berg, A.; Oei, T.I.

Published in:
Mental Health Review Journal

Publication date:
2009

Verschenen in: Attachment and psychopathy in forensic patients, Mental Health Review Journal, 2009, vol. 14, no. 3, p. 40-51.

Attachment and psychopathy in forensic patients

The (in)ability of severely psychopathic patients to commit to therapeutic relations, considered from the perspectives of Attachment Theory and Mentalization-Based Treatment

Van den Berg, A. (Anne)□ & Oei,T.I. (Karel)□

□ De Rooyse Wissel, Forensic Psychiatric Hospital, Venray

□ Institute of Criminal Law and Victimology, Department of Forensic Psychiatry, Tilburg University

Correspondence Address: Anne van den Berg

De Rooyse Wissel

Forensic Psychiatric Hospital

Postbus 433

5800 AK Venray

The Netherlands

a.bergvan@dji.minjus.nl or anne@berg-op.nl

Key points: attachment, antisocial, mentalization, object, psychopathy, psychotherapy, research, self, subject, therapeutic relationship.

Abstract

Effective treatment of patients with severe psychopathy is very difficult to achieve. This conclusion may be drawn from an extensive examination into the usage of the term 'psychopathy' in scientific research literature, in theoretical development from various psychological schools of thought, in the practice of therapy and in assessment. The central issue for the authors of the present article is the inability of severely psychopathic patients to commit to the patient-therapist relationship. Attachment Theory and Mentalization-Based Treatment are used here to define the cause and nature of this inability, which is incurred in very early childhood. The two above-mentioned models can aid in the development of more dynamic definitions of psychopathy, better suited to dynamic therapy formats.

The ways in which psychopathy is defined partly account for a number of problems encountered in the practice of therapy. The authors assume that the treatment of psychopathy should be interactional and should match patients' individual levels of psychological development and mentalization; highly psychopathic patients often perceive others as objects ie as part of the context, not as subjects ie autonomous personalities.

The authors propose to conduct further research in order to verify the validity of their hypothesis. They also put forward a number of suggestions for therapy formats with a view to establishing effective working relationships with psychopathic patients.

Introduction

The quality of patient-therapist relationships is a powerful predictor of therapy results (Lambert, 1992). It is, however, notoriously difficult to establish therapeutic relations with those forensic patients who suffer from a severe degree of psychopathy. The general assumption is that the difficulty lies in certain personality traits which prevent such patients from entering into any reciprocal relationships (Cleckley, 1982). Typical traits, for instance superficial charm or the inability to really love others, are believed to make meaningful and reciprocal relationships – indispensable as they may be for the establishing of therapeutic relations - impossible for those who suffer from psychopathy. In this article the question is addressed how we may break out of this circular argument. Unsurprisingly, numerous therapists and researchers in forensic psychology have come to the conclusion that psychopathy is untreatable (Cleckley, 1982; Strassburger, 1986).[1]

This article examines the conceptions of psychopathy, of the patient-therapist relationship and of the necessary qualities of that relationship for therapists, for patients and for the interaction between the two. The ways in which those conceptions have been formulated as concepts are indications of where solutions to the vicious circle may be found. Attachment theory (Bowlby, 1969, 1973, 1980) and Mentalizsation-Based Treatment (Allen & Fonagy, 2008) both provide promising approaches in this respect, which are briefly described along with an outline of their possible implications for treatment and research.

Psychopathy in theory and scientific literature

The nature and scope of this article necessarily limits the discussion of aspects of the psychopathy concept to what is relevant here. Neurobiological research concerning psychopathy for instance, will be entirely omitted. The term 'psychopath' is avoided as much as possible because it has become overburdened with meaning; instead, such terms as 'psychopathy', 'psychopathic personality' or 'those who suffer from psychopathy' - limited as the 'suffering' may be in this instance - will systematically be used.

[1] In empirical research it has been suggested that psychopathic patients will be more dangerous after treatment (Rice *et al,* 1992). However, more recent reviews show there is no evidence for the untreatability of psychopathic patients (Salekin, 2002; D'Silva *et al*, 2004). Nowadays the opinion is, based on empirical research, that psychopathy is treatable (Skeem *et al*, 2002, Caldwell *et al*, 2006). Former skeptics even endorse this (Harris & Rice, 2006).

The conception of psychopathy has known a long history. It was described - as a psychological trait - by Pinel as early as 1801; in 1891 Koch was the first to define it as psychopathy (psychopathic inferiority complex). Over the past two centuries, definitions have been based on typical behaviours (lying), underlying traits (hysteria), social/environmental factors (the sociopath) or biological features (the 'natural born' criminal). The psychopathy concept as it is given in Hare's *Psychopathy Checklist - Revised* (PCL-R) (2006) is based on 20 traits and behaviours which are symptomatic of the syndrome. The traits stem from the above-mentioned tradition where the description of symptoms as traits is predominant. Important exponents of such schools of thought are Cleckley and McCord (1964).

Another perspective comes from learning theory, which describes criminal behaviour as 'learned' ie rewarded in the interaction with others: an example is the acquiring of status in peer groups. According to this theory, interpersonal connections may lead to cognitive distortions in the perception of right and wrong and thus instill antisocial attitudes. These antisocial thoughts and actions are associated with a variety of thinking patterns whose aim is to minimize personal frustration. Examples of such patterns are: rationalization, trivialization, distortion. The term 'psychopathy' is not suited to this school of thought, whereas 'criminal behaviour' – a substantial component of psychopathy - is. Hirschi (1969) and *Sutherland* (1970) represent this school of thought.

Yet another perspective is given by psychoanalytic tradition with the construct of an intrapsychic sphere of influence based on structural diagnostics as exemplified by Kernberg (1992). Those who suffer from psychopathy are deemed to have sustained damage to personality development at a very young age, resulting in primitive internalized relations (object-relations), lack of conscience, violent drives, barely manageable affects and immature defence mechanisms. The dynamics of such intrapsychic constellations then create psychopathic personality structures and disorders. Meloy (1988) belongs in this tradition, according to which pathological intrapsychic dynamics within the self manifest themselves through psychopathic behaviours such as criminality.

The next viewpoint to be looked at is that from attachment theory, which defines psychopathy from the angle of developmental psychology. The psychopathic personality is here regarded as the outcome of deprivation during infancy, and also as detectable from a very young age through early antisocial behaviours. Bowlby (1944) and Winnicott (1971) stand in this tradition and focus on very early interpersonal development, where child-carer

relationships may give rise to unsafe attachment styles of which criminal behaviour can be a component. This point of view will be further discussed in a separate section.
So, psychopathy is a psychological construct developed gradually over a long period of time and involving differing theoretical frameworks, each with their own explanatory theories. Personality traits, personality structure and social cognition have been discussed in this connection, as have attachment theory and developmental psychology. Other explanation models are also possible, such as those proposed by biology and neuropsychology. Each province has its own definition of psychopathy; a comprehensive theory, if at all possible, does not exist, nor does a satisfactory definition. At the moment, the outcome of Hare's Psychology Checklist Revised (1999) is generally used for the measuring of psychopathy. (Scores per item are between 0 - 2, the total score ranges from 0 – 40; high scorers (>30) are classified as psychopathic.)

Scientists and theoreticians abhor the inconsistencies in the defining of psychopathy, since they make their work more difficult.

Psychopathy and empirical research

As a consequence of the above, researchers such as Hare (1999) have sought more empirical ways of determining psychopathy, using questionnaires and checklists. From 1980 onwards, Hare has been working on the construction of a valid instrument for measuring levels of psychopathy: the *PCL-R*. No research can take place without some previously specified organizing system: Hare, following Cleckley, decided on classification according to personality traits and antisocial behaviours. Through several types of factor analysis he arrived at the following four factors indicating psychopathy:

1. *interpersonal factor*: an arrogant and deceptive interpersonal style e.g. grandiosity or manipulative seeking of control over others through intimidation and deception;
2. *affective factor:* deficient emotional connection with others; insensitivity, ruthlessness, indifference to any harm done to others; lack of remorse; emotional volatility; lack of attachment to others; emotionally cold;
3. *lifestyle factor*: an impulsive, irresponsible lifestyle; impulsive decisions; unrealistic long-term planning; ignoring of commitments or obligations; persistent irresponsible choices;
4. *antisocial factor*: persistent rejection of rules and restraints; externalization; severe behavioural problems during childhood; seriously antisocial conduct and/or criminal

offences as a teenager; threatening behaviour such as verbal abuse or physical violence; violation of supervisory regulations.

The PCL-R is highly reliable and valid in determining levels of psychopathy, but it is also used – against Hare's advice (2006) – as 'objective' evidence for judicial purposes in order to evaluate the risk of future conduct problems. The relative straightforwardness of the checklist unfortunately encourages such improper usage, which has recently been severely criticized (Van den Berg, 2006).

Moreover, the checklist itself has been criticized (Cooke *et al*, 2008) for inflexibility caused by the fact that the checklist is based on fixed personality traits and conduct history, instead of using more dynamic factors. Once a PCL-R score has been established, it will be lifelong. The changeable and dynamic factors in psychopathy - which are after all the main focus of treatment - have not been taken into account. In reaction to the fixed trait approach, Cooke *et al* have for some time now been occupied with the designing and validating of the *Comprehensive Assessment of Psychopathic Personality* (CAPP), based on forensic therapists' and researchers' experiences in forensic care (Cooke *et al*, 2008). These researchers composed the following six domains identifying psychopathic personality problems:

a. *self domain*: problems with identity or individuality; self-centredness and self-aggrandizing. This domain focuses on having accurate consciousness of identity, qualities and desires;
b. *emotional domain*: problems with mood regulation: experiencing shallow and labile emotions. The focus here is on the appropriateness of affective responses;
c. *dominance domain*: difficulties with interpersonal agency: excessive status-seeking and assertiveness. This focuses on power or control in interpersonal exchanges
d. *attachment domain*: difficulties with interpersonal affiliation: deficient forming and maintaining of personal bonds. This domain centres on the intimacy and mutual acceptance that are part of more intimate relationships.
e. *behavioural domain*: problems with the organization of goal-directed activities; being impulsive and sensation seeking. Behavioural regulation and the capacity to handle life tasks in a systematic manner are central here.
f. *cognitive domain*: problems with mental flexibility and adaptability. This focuses on how information is encoded and processed, how thoughts are organized and attributions made.

Each domain has five to seven dimensions.

Such a more dynamic assessment system creates more elbowroom for forensic therapists in treating psychopathic personalities. Another step ahead in the assessment of psychopathy would be for measurings to be conducted from a variety of angles e.g. therapy concepts, therapeutic principles and psychological levels. Reasoning 'from the outside going in', the assessment trajectory might then run as follows: objectively observable symptoms; systems and contexts; consciously accessible schemas; implicit schemas such as defence mechanisms and intrapsychic conflicts; internal attachment representations; genetic predispositions. The result would be a variegated and multidimensional diagnostic instrument which can do justice to the complexities of the psychopathy concept (Eurelings-Bontekoe *et al*, 2003).

Psychopathy and psychotherapeutical practice

As was mentioned in the introduction, patients with psychopathy are difficult to treat. This is found both in scientific research and in the practice of therapy. Meta-analyses such as those from Warren *et al* (2003), the Dutch Health Council (Gezondheidsraad) (2006) or Andrews *et al* (1990) have led to the conclusion that, although there is some evidence that psychopathy as a personality disorder may be treatable to a certain extent, there is no positive proof.
The meta-analyses are centred on differing aspects and directions in psychopathy: Warren focuses on he Dangerous and Severe Personality Disorder, the Health Council on the Antisocial Personality Disorder and Andrews on criminal behaviour as such; these are cognate concepts partially belonging in the psychopathy range. The meta-analyses are not mutually comparable, since they contain differing conceptual definitions and disparate target groups.
Anrews *et al* (1990) attempt to avoid those problems by formulating basic principles derived from scientific research, which, when implemented in mutual coherence, should result in a reduction of recidivism. These pragmatic principles, the *'What Works'* principles, are formulated as follows:

1. *the risk principle*: determination of risk factors by means of risk assessment tools, crime analysis and checklists like the PCL-R; the higher the score on this principle, the more intensive the treatment will be;
2. *the need principle*: this implies specification of which needs are to be addressed; the point of departure here is that those needs which are directly linked to criminal behaviour – the *criminogenic needs* – should be listed and dealt with. This principle is

associated with dynamic, and therefore changeable, delinquency factors. Criminogenic needs are to be distinguished from non-criminogenic ones; as an example of the former Andrews *et al* mention 'antisocial attitudes', while the latter are exemplified by 'self-appreciation'. More recent studies have added protective factors to the need principle;

3. *the responsivity principle*: treatment formats should be adapted to patients' learning styles and to their intellectual, cognitive and social capabilities. Andrews & Bonta (2003) consider the cognitive-behavioural approach, customized as described above, to be the best treatment strategy, especially if behaviour is made concrete and manifest and if much attention is given to patient motivaton;
4. *the integrity principle*: the principles mentioned above should be applied consistently and in cohesion.

It has already been noted that the 'What Works' treatment principles do not provide insights into the psychopathic personality; instead, they address criminal conduct itself and factors conducive to such conduct. Not based on a single, coherent theory of psychopathy, they are pragmatic in nature, the outcome of extensive study of literature from a variety of therapeutic disciplines, and also of their own and others' research. In *The Psychology of Criminal Conduct* (2003), Andrews *et al*, researchers by profession, express their preference for cognitive-behavioural therapy as treatment for criminal behaviour. In our opinion these researchers are going too far in their conclusion. Their system of ordering therapeutic material is characterized by a cognitive behavioural approach. They check treatment programs according to this principle and conclude as a matter of course that the most effective programs are the cognitive behavioural ones. This way of researching and reasoning reminds us of research done by Luborski *et al* (1999) concerning metaresearch. Their findings are that 70-80% of the variation in outcomes of treatment research is connected with the researcher's own therapeutic allegiance.

In the discussed meta-analyses it is also remarked that empirical studies are very difficult to compare because, as has been noted above, they contain a plethora of concepts to indicate typical characteristics of the personality disorder, psychopathy. In addition to deficiencies in the defining of the disorder, many research-technical shortcomings were also found; those are, however, outside the scope of this article.

Descriptive studies of therapeutical practice essentially bring up the same problems. In their article 'The Influence of Psychopathic Traits on Response to Treatment'(2007),

Thornton & Blud explain in what ways psychopathic traits can influence treatment. As the title indicates, their inventory is based on such personality traits as are found in psychopathy. A few of them are:

1. failing to give accurate, personally relevant accounts of past history and functioning, which give therapists partially fictitious stories to work through;
2. insincere intentions whose goal is to manipulate therapists: the patient is in fact unwilling to alter conducts. The patient will for instance come up with some bogus solution;
3. disrupting group processes; the aim here is domination of both the therapist and the group;
4. regarding treatment as just another opportunity to con or dominate;
5. seeing no reason for personal change, which can be traced back to grandiose self-perception;
6. shallow affect and lack of empathic engagement: any attempt to focus the patient's attention on the effects of their conduct on other people, victims, is a waste of energy. This also goes for anger management;
7. difficulty in complying with sets of rules and conventions necessary for realizing treatment results.

These psychopathic traits can also have their effect on staff members who may become burnt-out by all the manipulations they have had to deal with. They may begin to doubt their own faculty for judgment or they may over-identify and end up overstepping the mark by beginning an intimate relationship with a patient or smuggling forbidden substances or goods. Also, staff members may become divided and so undermine therapeutic regimes and working climates.

So, Thornton & Blood's examples deal with psychopathic traits which will impede the progress of therapy. Such an approach identifies the patient who suffers from psychopathy as the critical factor in difficult communication. A different line of approach looks into interpersonal factors existing between patients and therapists, with both parties having their own explicit roles to play in their collaboration, or alliance. This approach might be called 'interpersonal' and will be discussed in the next section.

Psychopathy and therapeutic relations

According to Lambert (1992), the patient-therapist relationship is 30% responsible for therapy results; other deciding factors are: specific forms of treatment (15%), patients' hopes and expectations of change (15%) and external factors such as positive life events or spontaneous recovery(40%). Lambert's study deals mostly with milder psychological problems: the figures might very well be different for psychopathy, but those appear not to have been established so far. From research done by Essock *et al* (2006) it is known that with drug addicts the 40% external factor was proved to be the decisive treatment tool when it was enhanced by case management. This implies collaboration between key figures and official agencies in order to ensure addicts' best possible embedding in and adaptation to society. This approach has positive effects on drug abuse.

Examination of psychopathic personality profiles gives little hope of change for such patients where it concerns the therapeutic relationship. Patients' motivation is usually poor, because treatment is imposed by law and also because, as we have seen, there is little, if any, inner need for change in these personalities. These experiences have given rise to an undesirable and possibly harmful shift in forensic psychiatry: society instead of the patient is made client. Forensic psychiatry is treating patients, not for their disorders but for the disturbances they create in society. This line of treatment, reducing clients to risk factors, may lead to further depersonalization of psychopathic patients. The basis for treatment of these patients will be a rerun of the situation they have known from a very early age, that of being 'out of order'.

In order to answer the question how therapeutic relations can contribute to improvement of therapy results for psychopathic patients, the content of the therapeutic relationship needs to be further examined.

Bordin (1979) defines the therapeutic 'working alliance' as the agreement between patient and therapist on the goals of treatment and on the tasks of treatment; the third element of their definition is the quality of the emotional bond between the participants.

A different approach, presented by Trijsburg *et al* (2002), seeks to connect to patients' developmental histories. Therapeutic relations are here dissected into four levels, which will intermingle in practice:

1. *the primary relationship*, without object constancy or self-object differentiation: this concerns the pre-verbal level. The relationship is supportive in character and addresses developmental deficiencies caused by basic insecurity, vulnerability and early

childhood trauma. The primary relationship reflects the developmental history of numerous cases of psychopathy;

2. *the transfer relationship*, with some self-object differentiation: the others are seen as separate personalities but no distinction is made between what is real and what is not. Early relationships are relived in the reality of the therapeutic relationship. Here, too, elements of psychopathy can be seen;
3. *the work alliance,* with patients' adult personality aspects communicating with therapists about disturbing elements. The emphasis is on collaboration. There is realistic and adequate perception and interpetration of their own and others' behaviours. This type of working alliance does not occur with patients who are severely psychopathic;
4. *the real relationship*, with two adults communicating in a normal manner. Otherwise this relationship is the same as the working relationship.

The significance of the above definitions lies in the fact that therapists should establish those types of relations that are best suited to patients' individual levels of psychological development. So patients with severe psychopathy will mostly be treated at the primary level. Attachment theory provides useful starting points for sensible ways of developing the proper type of therapy relationship: how this may be realized will be discussed in the next sections.

A brief impression of attachment theory and its implementation in Mentalization-Based Treatment

Because the continuation of this article deals with concepts derived from attachment theory and Mentalization-Based Treatment (MBT), the following specifications of some key conceptions from attachment theory and MBT may be helpful.

Attachment behaviour may be defined as the behaviour of an infant, child or adult seeking or trying to sustain closeness or connection with the attachment figure, both verbally and non-verbally. Carer and child form an attachment relation by giving and receiving support/closeness. Attachment and bonding can only come about if the child is able to derive internal attachment representations from carer-child interactions. The attachment representation is the reflection and introjection of the carer's ways of handling the child.

Attachment representation can, from the above perspective, be seen as the way in which the child has made an internal model of early attachment experiences and thinks, feels and acts in accordance with that model.

MBT is an endeavour to enhance the ability to mentalize and reflect upon those early experiences. *Mentalization* is the ability to observe one's own behaviour and that of others in terms of motives and intentions. Development of the capacity for reflection and mentalization requires safe attachment to the carer (and, later in life, to the therapist).

The manner of processing information, emotions and thoughts is sometimes called the *internal working model*; its functioning is strongly related to the structure of the brain which contains two distinct forms of memory: implicit memory and explicit memory (Schmeets & Van Reekum, 2000). Sets of procedural rules within the brain (ie implicit memory) precede autobiographical (ie explicit) memory and organize the latter according to *how* things happened rather than to *what* happened and *why,* with any associated thoughts and feelings. Implicit memory also filters information for admittance into long-term memory and decides information quality (colouring).

In the interest of this discourse these theoretical concepts, which have proved their worth in the description and treatment of Borderline Personality Disorder (BPD), should be translated to psychopathy.

As indicated above, MBT implies the application of concepts and ideas from attachment theory to treatment of psychic problems: the therapist commits to a therapeutic relation which takes into account the patient's levels of (non-) mentalization.

The procedure is straightforward, dealing with the here and now, concentrating on form rather than content and focused on the patient's conscious awareness, in an atmosphere of support and empathy. All this can be done explicitly by addressing verbal and conscious aspects of the patient; or explicitly, by creating the appropriate therapy context and validating he patient's preoccupations without judgment – the last point is particularly important where it concerns early disturbances. Non-verbal techniques and information can be very helpful there.

The goal of MBT is making internal attachment representations safer for patients, so enabling them to reflect on themselves; to make choices about how to relate to others; and to experience correlations between needs, emotions and actions. Safer attachment representations may also positively influence sensitivity to other people's thoughts and feelings; this would allow more reflective and sensitive communication with others.

Psychopathy and attachment theory

According to attachment theory, a disorder like psychopathy is not the result of a set of fixed personality traits, but arises at a very early age, possibly caused or aggravated by genetic predispositions. Such an approach seems well-suited to the multidimensional personality dynamic that was described earlier in the discussion of assessment, and to the different levels of therapeutic relations. Clinical experiences with psychopathy have been summarized as follows (Van den Berg & Oei, 2006):

1. internal working models may cause the child's normal biological needs such as hunger, thirst, physical contact (comfort against pain) to be interpreted by the carer as power mechanisms, used by the child to gain control; the carer fails to recognize these primary urges, which create the attachment necessary for survival, for what hey are or even as expressions of affective needs;
2. the carer's attachment style is therefore centred on control of the child by means of exercising power; this may vary from disciplinary measures (e.g. strict time schedules) to physical abuse. The exercise of power may also imply ignoring the child: the carer refuses to be controlled by a baby; the result is neglect;
3. carers' internal working models contain numerous representations filled with aggression they have failed to regulate properly; these representations will be activated by the infant's demands. Such attachment relationships are largely determined by the acting-out of aggression;
4. the carer is not sufficiently capable of defining either verbally or non-verbally the child's affective need nor of reflecting this in their own posture. In this way many infants are faced with power and aggression instead of receiving warmth, love or training in the tolerance of anxiety and frustration;
5. words and concepts – second order representations – taught to such small children will be limited in scope, being mainly about the dimensions of power and winning or of their opposites, weakness and losing. The organization of attachment representations within the self will become biased, based as it is on limited conceptual frameworks. Internal working models like these can be compared to Bion's (1962) basic 'fight-flight' assumption;
6. the child may convert early trauma, caused by abuse and the disregard of anxiety by children as well as carers, into counter-aggression, also called 'predatory behaviour'; attack is the best defence here.

Unsafe attachment has far-reaching consequences for the evolvement of the 'self'. Experiences with the carer fill the self with 'strange', partial representations called 'strangers' by Meloy (1988) and 'aliens' by Bateman & Fonagy (2004). Such incomplete representations (disorganized representation) may lead to disintegration of the self. To stave off self disintegration, equilibrium is rigidly maintained. Only by egocentric behaviour towards the others and their context can patients hold their own. 'Strange' partial representations may also be externalized into projections on others: "I'm not aggressive, it's him."

With its dynamic description of psychopathy, attachment theory provides an explanatory theoretical framework but, as Van IJzendoorn (1997) points out, it is not the only foundation for explanation. Attachment theory outlines disturbances in the development of safe carer-child attachment, which are repeated in mutual relationships later in life.

Research done by Van IJzendoorn (Pfäfflin & Adshead, 2004) through the aid of the *Adult Attachment Interview* (AAI, George *et al*, 1996) has shown that forensic patients have significantly higher presence of unsafe attachment representations (ie dismissed and disorganized/unresolved attachment styles) than was found in the control groups. Dismissed and disorganized/unresolved attachment representations can fairly easily be identified in PCL-R items; factors 1 and 2: the interpersonal and affective factors, provide insights into how psychopathic patients avoid reciprocal relationships; factor 4: the *antisocial lifestyle* factor, corresponds to disorganized attachment representations, recognizable by impulsive and irresponsible behaviour.

A typical feature of the PCL-R factors is that patients with high scores will see the others as object, not subjects. With this observation we arrive at the root of psychopathy, ie the fact that these people have never learnt to see others as subjects: people with their own wishes and intentions. Instead, they see either continuations of themselves, or opponents. They themselves had very early experience of being treated as either objects or opponents by significant others, mostly carers. It has to be emphasized that the term 'object' in this context is not used in its broader meaning, as in 'object-relation theory' according to which the object is perceived or experienced as 'the other' person or thing ('not me'), distinct from 'me'.

Winnicott, in *Playing and Reality* (1971), explains how during the transitional period of growing awareness of the carer's separateness (from 'me' to 'not me'), a child may transfer familiar feelings of safety and trust to a 'transitional object'. Those familiar safe feelings can only be properly transferred to an object of equal emotional value , for example a teddy bear. It is necessary here that the carer has been (emotionally) available in a predictable manner; if

that has not been the case and unpredictability, rejection , abuse, and lack of 'containment' and 'attunement' (ie adequate limitation and reflection of the child's emotions and needs) were the norm from infancy onwards, transfer to safe 'transitional objects' is made very difficult. By way of survival strategy the child may then hold on to the experience of omnipotence which belongs roughly in the first year of life ('equivalent mode') (Bateman & Fonagy, 2004): the child endeavours to ban the threat of anything that is 'not me'. In forensic terms, everything and everybody has to cater to the omnipotence of these psychopaths, who are also called 'core psychopaths' or 'primary psychopaths'. To this category of patients, 'transitional objects' will be things like fancy weapons or aggressive dogs. During this phase there may be some sensitivity to others, to their context - not as autonomous entities but as continuations of the self ("I am the world"). In the following stage of the child's development, named 'pretend mode' by Bateman & Fonagy, the child does learn to distinguish between 'me' and 'not me' but the two are now experienced as separates, with no interactional connection. The child's disenchantment with the carer's separateness has frequently been described in developmental psychology.

Sufficient transitional space is indispensable for enabling the child to tolerate the non-continuous availability of the carer, otherwise the gap between 'me' and 'not me' will not be bridged and transformation of the others into autonomous personalities - subjects with their own individual intentions and feelings to identify and bond with - does not take place. Instead, the others are made into objects: those will not require any reciprocity. Consequently, mutual relationships will not be sought, since they carry the risk that overwhelming emotions take over (anxiety and anger at the'separation').

As long as mutual influencing fails to be experienced and learnt - as is the case with psychopathy - other ways of influencing others are needed in order to make life more predictable. To survive - which is what people with very unsafe attachment have to do - the obvious 'choice' would then be to enter into instrumental relations whose goal is the acquiring of power. Such relations are often internalized carer-child interactions (ie attachment representations), since the carer was unable to connect at the child's own developmental level.

From these explanations, provided by attachment theory, we may conclude that psychopathic personalities have, even at a very young age, never experienced carers, others, as (potential) attachment figures. They see others as parts of their context they have to relate to and deal with, for the sake of survival. To them, attachment quality is not about the seeking

of a ‘safe haven’, as Bowlby (1988) puts it, a place to come back to in times of need. Rather, others are perceived as contextual elements that have to be under control: others only serve to aid the pychopathic personality. Social adjustment, indispensable as it may be to human existence, will be brought about not by people but by context. Others may form an integral part of the context, and will have to be subdued so as to increase these patients’ power sensations.

Whenever, in spite of all that, personal attachment does develop, others will be perceived by the psychopathic personality either as appendages (‘equivalent mode’), as entirely separate (‘pretend mode’) or, in somewhat maturer relationships, as useful providers of material services (‘teleological mode’) (Allen & Fonagy, 2006). The ‘modes’ transform others into creatures without any wishes or intentions of their own.
Influencing by the other, if it happens at all, will have to be neutralized as rapidly as possible.

Psychopathy and context

The previous argumentation leads to the assumption that psychopathic personalities will not establish reciprocal social relations. Their avoidance of such relations implies that any influencing of their personalities or behaviours will have to come from the context - of which other human beings just may be part. Influencing will then be oriented to implicit rules rather than explicit ones, since explicit rules cannot alter the patient’s systems of information processing; explicit training will allow those with high scores on PCL-R factors 1 and 2 to use any explicit information they are given to their own advantage, ie for the perfecting of their control systems. Treatment aimed at improving the affective and interpersonal levels of the therapeutic relationship will be averted by turning it into a power game. Empathic responses from therapists will, particularly in the earlier stages of therapy, be regarded as personal attacks and be punished with fits of anger which may or may not be faked.
Context-based influencing has been known for a long time but has more recently faded into the background. The above-mentioned metastudies show that Community Based Treatment (CBT) for offenders, including those suffering from psychopathy, has produced favourable results (Warren, 2003). In terms of attachment theory, it may be concluded that treatment results for people with psychopathy largely depend on how patients relate to their contexts; starting from context, implicit rules contained in the internal working model may gradually be

adjusted. The internal rules may be modified by providing context-based, non-threatening information -during individual therapy for instance-, perhaps as follows:

1. physical features: from the start, the patient file is on the table where sessions take place; the patient's name is written large on the cover; file documents are arranged in chronological order and can be consulted on request by the patient; another important feature is the door, which is always ajar to show that the patient is expected;
2. timing features: therapy sessions are held at regular, fixed hours; the therapist is always on time;
3. location features: sessions are always held at the same location in order to promote object constancy;
4. posture features: the therapist mirrors the patient's posture by means of imitation, relaxing at intervals by way of example; therapist and client always shake hands at the end of each session;
5. relational features: at he end of each session the therapist makes a casual remark along the lines of "Good job today" or "Well done", avoiding personal words like 'me' or 'you'.

These implicit messages, delivered in a variety of ways, are meant to improve the quality of the patient-therapist relationship on a pre-verbal level by working on whatever the patient's internal working model may be the oriented to (Van den Berg & Oei, 2006).

In addition to context-based exemplifications in individual therapy, the clinical environment also offers numerous possibilities with regard to context. Some of the beneficial contextual features that can be found in clinical settings are: transparence, clarity, consistency, predictability and regularity (Berkouwer, 2004).

These forms of treatment are protracted and can therefore evolve gradually, along the lines of MBT; the point of departure is the psychopathic patient's individual level of psychological development. Developmental levels have been indicated very adequately by Trijsburg *et al* (2002) in their study of the various types of patient-therapist relationship.

Attachment, levels of psychopathy and the therapeutic relationship: research design

Findings and conclusions from this investigation of therapeutic relations with severely psychopathic patients, ask for further research based on attachment theory and on the therapeutic relation itself. For this purpose we propose to use the following questionnaires:

1. for attachment style and its associated levels of insecurity: *Attachment Style Questionnaire*, (ASQ) (Feeney *et al*, 1994);
2. for the levels of self-awareness and sensitivity to others: *Autonomy Connectedness Scale* (ACS-30) (Bekker & Van Assen, 2006);
3. for evaluation of therapist availability and suitability according to patients and to therapists: *Psychological Availability and Reliance on Adult* (PARA) (Schuengel *et al*, 2003);
4. for patients' and therapists' experiences of therapeutic relations: *Working Alliance Inventory* (WAI) (Horvarth&Greenberg, 1989);
5. for levels of psychopathy: *Psychopathy Checklist - Revised* (PCL-R) (Hare, 2003).

The necessary empirical research is to be conducted at a Dutch High Security Hospital where seriously criminal forensic patients undergo mandatory long-term treatment.

Two groups of forensic patients suffering from psychopathic personality disorder will be compared on attachment style: one group representing relatively high scores on the PCL-R checklist, the other containing lower scorers. The assumption is that patients with high PCL-R scores consider themselves to have relatively safe attachment styles, whereas the lower scores from the other group will be more in line with the patients' own attachment perceptions. Therapists on their part may find that those with high scores show unsafe attachment, while lower scores are more associated with safe attachment. This difference in perception between patients and therapists is due to the high scorers' pathology preventing them from seeing the reality of their own unsafe attachment style. The hypothetical explanation for such an outcome is that severe psychopathy implies strong self-awareness combined with poor sensitivity to others; this is less true for lower scorers ie the less severe cases. When compared to those with low scores, higher scorers will experience their therapists as less available and less attentive. Finally, clients with high scores may be more dissatisfied with the patient-therapist relationship as such, particularly on an emotional level. The research proposed above is to take place in late 2009; results will be published by early 2010.

Conclusion and discussion

The treatment of patients who suffer from severe psychopathy is difficult to define in a consistent manner. The psychopathy concept contains numerous ramifications and theoretical viewpoints. Scientific and diagnostic research, too, produces a variety of approaches and outcomes. Taking the 'What Works' principles as points of departure, cognitive-behavioural

therapy appears to provide an effective format for treatment of criminal behaviours; the treatment tool *par excellence*, the therapeutic relation itself, offers possibilities for defining psychology from the angle of developmental psychology. Attachment theory and Mentalization-Based Treatment both are useful in producing more dynamic descriptions of these patients, thus enabling more custom-made treatment formats. Because commitment to therapeutic relations is very difficult for the seriously psychopathic patient, the conclusion from the studied literature is that the early stages of treatment should be contextual in nature, using implicit treatment methods rather than explicit ones. Therapeutic Community Treatment would be perfectly suited to this purpose - not 'Democratic Community Treatment' but an imposed framework to aid collaboration and communication with and among patients. The high security Forensic Psychiatric Hospitals in The Netherlands are excellent environments for such treatment formats: an enforced therapy context can be helpful in a step-by-step therapeutic process of moving towards more relation-oriented treatment.

It is assumed here that patients, even those with severe psychopathy - or at least a number of them - do have the ability to enter into therapeutic relations; this assumption may be questioned from the biological standpoint. Also, Bateman & Fonagy (2008) express doubts about MBT where it concerns treatment of patient with 'core psychopathy'.

It has not been queried in this study whether the term 'psychopathy' might be a misnomer for any particular patient groups. In the specialist language of psychology the term 'Psychopathic Personality Disorder' (PPD) is also used; in DSM-IV the term 'psychopathy' does not even occur, whereas 'Antisocial Personality Disorder' (ASPD) does. The latter classification, however, does not entirely cover the PPD group. In choosing any definition its aim should be the decisive factor; from the therapist's angle, it is especially important to describe psychopathy in dynamic terms rather than in sets of fixed traits and syndromes. More dynamic definitions would be of great advantage to treatment: the therapist's profession itself is a dynamic by nature, as may be shown by the organization and evolution of patient-therapist relations.

Patient-therapist relationships are always repetitions of earlier ones. Patients have incurred a very early developmental disorder; to accentuate its particular characteristics, 'Antisocial Relational Development' (ARD) would be a more satisfactory term since it covers those factors which will be made topical by the patient-therapist relationship, and which can function as explanation models. The emphasis is on psychopathic patients' difficulties with reciprocity.

This approach, suitable as it may be for the practice of psychotherapy, deals with only one of many aspects of the psychopathy concept. Further theoretical development, as well as more intelligent and mutually comparable research including genetic-biological viewpoints will be needed for the unravelling of each of the numerous facets of psychopathy, in order to come to more effective treatment methods.

*FPC de Rooyse Wissel, Postbus 433, 5800 AK Venray, The Netherlands.

References

Allen JG & Fonagy P (2006) *Handbook of Mentalization-Based Treatment*. NewYork: John Wiley and Sons Ltd.

Andrews DA, Zinger I, Hoge R, Bonta J, Gendreau P & Cullen FT (1990) Does correctional treatment work? A clinically-relevant and psychologically informed meta-analysis. *Criminology* **28** 369-404.

Andrews DA & Bonta J (2003) *The Psychology of Criminal Conduct*. Third edition. Cincinatti: Anderson Publishing co.

Bateman AW & Fonagy, P (1999) The effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomnized controlled trial. *American Journal of Psychiatry* **156** 1563-1569.

Bateman AW & Fonagy P (2004) *Psychotherapy for Borderline Personality Disorder. Mentalization Based treatment.* Oxford: University Press.

Bateman,AW & Fonagy P (2008) Comorbid antisocial and borderline personality disorders: mentalization based treatment. *Journal of Clinical Psycholog,* **64** 181-194.

Bekker MHJ & Van Assen ALM (2006) Autonomy connectedness scale (ACS-30). *Journal of Personality Assessment* **86** 51-60.

Berkouwer AY (2004) *Handboek de Psychoanalytische Setting. Anatomie van een Plek* [Handbook the Psycho-analytic Setting. Anatomy of a Spot]. Amsterdam: Boom.

Bion WR (1962) *Learning from Experience*. London: Heinemann.

Bordin E (1979) The generalizability of the psycho-analytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice* **16** 252-260.

Bowlby J (1944) Forty-four juvenile thieves: their characters and home life. *International Journal of Psycho-Analysis,* **25** 107-127.

Bowlby J (1969) *Attachment.* Attachment and Loss.Volume 1. London: Hogarth Press.

Bowlby J (1973) *Separation: Anxiety & Anger*. Attachment and Loss.Volume 2. London: Hogarth Press.

Bowlby J (1980) *Loss: Sadness & Depression,* Attachment and Loss.Volume 3. London: Hogarth Press.

Bowlby J (1988) *A Secure Base: Parent Child Attachment and Healthy Human Development*. New York: Basis Books.

Caldwell M , Skeem J , Salekin R & Van Rybroek G (2006) Treatment response of adolescent offenders with psychopathy features, *Criminal Justice and Behavior* **33** 571-596.

Cleckley H (1982) *The Mask of Sanity*. Revised Edition. Mosby Medical Library.

Cooke D J, Hart S D, Logan C & Michie C (2008) *Evaluating the Construct of Psychopathic Personality Disorder: The Development of a Comprehensive Clinical Assessment*. Manuscript under preparation.

D'Silva K, Duggan C & McCarthy L (2004) Does treatment really make psychopaths worse? A review of the evidence. *Journal of Personality* **18** 163-177.

DSM-IV (1994) *Diagnostic and Statistical Manual of Mental Disorders.* APA.

Essock S, Mueser K, Drake RE, Covell NH, McHugo GJ, Frisman LK, Kontos NJ, Jackson CT, Townsend D &. Swain F (2006) Comparison of ACT and standard case management for delivering integrated treatment for co-occuring disorders*, Psychiatric Services* **57** 185-196.

Eurelings-Bontekoe EHM & Snellen WM (2003) Multidimensionale diagnostiek [Multidimensional Assessment]. In Eurelings-Bontekoe EHM & Snellen (Eds) *Dynamische Persoonlijkheidsdiagnostiek [Dynamic Personality Assessment]*. Lisse: Swets & Zeitlinger.

Feeney JA, Noller P & Hanrahan M (1994) Assessing adult attachment. In Sperling MB & Berman WH (Eds) *Attachment in Adults: Clinical and Developmental Perspectives.* New York: Guilford Press.

George C, Kaplan N & Main M (1996) *Adult Attachment Interview.* Third edition. Unpublished manuscript. Berkeley: University of California.

Gergely G & Watson JS (1996) The social biofeedback theory of parental affect-mirroring: the development of emotional self-awareness and self-control in infancy. *International Journal of Psychoanalysis* ***77*** 1181-1212.

Gezondheidsraad (2006) *Preventie en Behandeling van de Antisociale persoonlijkheidsstoornis* [Prevention and Treatment of the Antisocial Personality Disorder]. Publication nr. 2006/17. 's Gravenhage, Gezondheidsraad.

Hare RD (1999) *Without Conscience: the Disturbing World of the Psychopaths*. London: Guilford Press.

Hare RD (2003) *The Psychopathy Checklist—Revised*. Second Edition. Toronto: Multi-Health Systems.

Hare RD. & Neumann CN (2006) The PCL-R assessment of psychopathy: development, structural properties, and new directions. In Patrick C (Ed) *Handbook of Psychopathy.* New York: Guilford.

Harris GT & Rice MJE (2006) Treatment of psychopathy. a review of empirical findings. In Patrick C (Ed) *Handbook of Psychopathy*. New York: Guilford.

Hirschi T (1969) *Causes of delinquency*. Berkeley: University of California Press.

Horvath AO & Greenberg LS (1989) Development and validation of the working alliance inventory. *Journal of Counseling Psychology* **36** 223-233.

Kernberg OF (1992) *Aggression in personality disorders and perversions.* New Haven and London: Yale University Press.

Koch JL (1891) *Die Psychopatischen Minderwertigkeiten* [The Psychopathic Inferiority Complexes]. Ravensburg: Maier.

Lambert M (1992) Implications of outcome research for psychotherapy integration. In Norcross JC & Goldstein MR (Eds) *Handbook of Psychotherapy Integration*. New York: Basic Books.

Luborsky L, Diguer L, Seligman DA, Rosenthal R, Krause ED, Johnson S, Halperin G, Bishop M, Berman JS & Schweizer E (1999) The researcher's own therapy allegiances: a 'wild card' in comparisons of treatment efficacy. *Clinical Psychology: Science and Practice* **6** 95-106.

McCord W & McCord J (1964) *The Psychopath: an Essay on the Criminal Mind*. Princeton Nj: D Van Nostrand.

Meloy JR (1988) *The Psychopathic Mind. Origins, Dynamics, and Treatment*. Northvale: Jason Aronson Inc.

Pfäfflin F & Adshead G (2004) *A Matter of Security. The Application of Attachment Theory to Forensic Psychiatry and Psychotherapy*. London and New York: Jessica Kingsley Publishers.

Pinel P (1801) *Traite Medico Philosophique sur l'Alientation Mentale*. Paris: Caille et Ravier.

Rice ME, Harris GT & Cormier CA (1992) An evaluation of a maximum security therapeutic community for psychopaths and other mentally disordered offenders. *Law and Human Behavior* **16** 399-412.

Salekin R 2002 Psychopathy and therapeutic pessimism. Clinical lore or clinical reality? *Clinical Psychology Review* **22** 79-112.

Schmeets MGJ & Van Reekum AC (2000).De psychotherapie en haar toekomst binnen de psychiatrie. Een poging tot integratie van nieuwe inzichten [The psychotherapy and its future within the psychiatry. An attempt to integrate new views]. *Tijdschrift voor Psychiatrie* **42** 459-467.

Schuengel C, Venmans JAMA, Van IJzendoorn MH & Zegers MAM (2005) *Gehechtheidstrategieën van Zeer Problematische Jongeren. Onderzoek, Diagnostiek en*

Methodiek [Attachment Strategies of Very Problematic Youth. Research, Assessment and Methodology]. Amsterdam: SWP.

Skeem JL, Monahan J & Mulvey EP (2002) Psychopathy, treatment involvement, and subsequent violence among civil psychiatric patients. *Law and Human Behavior* **26** 577-603.

Strassburger LH (1986) The treatment of antisocial syndromes. In Meloy JR (ed) *The Mark of Cain, The psychoanalytic Insight and The Psychopath (2003).* Hillsdale: The Analytic Press.

Sutherland EH & Crerssy DR (1970) *Principles of Criminology*. Sixth edition. New York: Lippincott.

Thornton D & Blud L (2007) The influence of psychopathic traits on response to treatment. In Hervé H & Yuille JC *The Psychopath, Theory, Research and Practice.* USA: Lawrence Erlbaum Associates.

Trijsburg RW, Knaeveldsrud C & Vervaecke GAC (2002) De therapeutische relatie en de werkalliantie [The.therapeutic relation and the working alliance]. In Trijsburg RW, Collumbien ECA & Lietaer G (Eds) *Handboek Integratieve Psychotherapie* [Handbook Integrative Psychotherapy]. Utrecht: De Tijdstroom.

Van den Berg A (2006) Risico's van risicotaxatie [Risks of risk assessment] *Tijdschrift voor Psychotherapie* **32** 277-287.

Van den Berg A & Oei TI (2006) Gehechtheid en antisociale relatievorming [Attachment and antisocial relation development]. In Oei TI & Groenhuijsen MS (Eds) *Capita Selecta van de Forensische Psychiatrie anno 2006* [Capita Selecta of the Forensic psychiatry 2006]. Deventer: Kluwer.

Van IJzendoorn MH (1997) Attachment, emergent morality, and aggression: toward a developmental socioemotional model of antisocial behavior. *International Journal of Behavioral Development* **21** 703-727.

Warren F, McGauley G, Norton K, Dolan B, Preedy-Fayers K, Pickering A & Geeds JR (2003) *Review of Treatments for Severe Personality Disorders*. Londen: Home Office Online Report.

Winnicott DW (1971) *Playing and Reality.* London: Tavistock Publications.